Reason's whole pleasure, all the joys of sense,
Lie in three words, --*health, peace, and competence.*
...Alexander Pope

Commonwealth of Massachusetts

Board of Registration in Medicine

Annual Report 1999

Mission for the New Millennium

Health care excellence as the goal and motivation for all Board policies.

Peace of mind for patients through innovative programs to educate and inform.

Competence of all Massachusetts physicians ensured through excellence in licensure and enforcement.

Argeo Paul Cellucci
Governor

Jane M. Swift
Lieutenant Governor

Massachusetts Board of Registration in Medicine

1999 Annual Report

Mary Anna Sullivan, *MD*
Chair, Board of Registration in Medicine

Walter Prince, *JD*
Vice-Chair

Peter Madras, *MD*
Secretary

Arnold Relman, *MD*
Physician Member

Rafik Attia, *MD*
Physician Member

Nishan Kechejian, *MD*
Physician Member

Peter Gelhaar, *JD*
Public Member

Jennifer Davis Carey
Director,
Office of Consumer Affairs & Business Regulatiion

Board of Registration in Medicine 1999

The Board is comprised of seven members, five physicians and two public members, who are appointed by the Governor. Board Members may be appointed to only two consecutive terms, but Members sometimes serve beyond the end of their terms until a new Member is appointed.

Mary Anna Sullivan, MD
Board Chair

Dr. Mary Anna Sullivan joined the Board of Registration in Medicine in 1996. She has chaired the Board since 1998. Dr. Sullivan is a graduate of Dartmouth College and Columbia University College of Physicians and Surgeons. She trained in Psychiatry at McLean Hospital and Brigham & Women's Hospital. She was recently named Chair of the Department of Psychiatry at the Lahey Clinic.

Walter Prince, JD
Vice-Chair, Public Member

Walter Prince is the Vice Chair of the Board of Registration in Medicine. He is a partner at the law firm of Prince, Lobel and Tye, having received his Juris Doctor from Boston College Law School in 1974. In his career, he has served as General Counsel to the MBTA, the Chief of the Major Drug Traffickers Prosecution Unit of the United States Attorney's Office, and Attorney for the Roxbury Defenders Committee.

Dr. Peter Madras
Board Secretary

Dr. Madras joined the Board in 1995 and serves as the Board Secretary. He is a graduate of McGill University Faculty of Medicine. He trained at both Boston City Hospital and the University of Toronto. Dr. Madras is currently associate professor of surgery at Harvard Medical School and a transplant surgeon at the Beth Israel Deaconess Medical Center. He is the Board Secretary and serves on the Complaint Committee and the Patient Care Assessment Committee.

Report of Board Chair Dr. Mary Anna Sullivan

Promises Kept.....

In March 1999, members of the Board of Registration in Medicine held a press conference to respond to public concerns about the trustworthiness of the Agency in meeting one of its prime responsibilities – the investigation of complaints against Massachusetts physicians. At that press conference, the Board reassured the public that it would undertake a massive review of the Agency's performance and report the results of the review to the public in May 1999.

I am proud to report that our promise to the people of Massachusetts has been fulfilled. We have discovered that decisions made by prior Boards to dismiss complaints were appropriate. The Board members are confident that the public has been well served and adequately protected by the Agency's disciplinary action decisions.

In addition, the Board members are confident that all initiatives proposed in the May Special Report will be achieved in a timely manner. The Agency has continued to make progress on these issues despite a high level of staff turnover and other challenging factors.

I thank and salute my fellow Board members for their meritorious and selfless service to the people of Massachusetts. Under very difficult circumstances, these dedicated volunteers have maintained the leadership necessary to achieve our goals.

On behalf of the members of the Board of Registration in Medicine, I offer this year-end review of the Agency's accomplishments. We are grateful to the Legislature and the Governor for increased funding to help us to meet our responsibilities. We are also grateful to the people of Massachusetts for giving us the opportunity to regain their confidence.

In the May Report, the Board outlined specific long and short-term goals for various projects. An update on the Agency's progress on these projects, as of December 1999, follows.

Rafik Attia, MD
Physician Member

Dr. Attia joined the Board in 1991. He is an anesthesiologist on the North Shore. and a former Board Chair. Dr. Attia has been instrumental in establishing quality assurance programs at the Board. Dr. Attia graduated from Cairo's Ain Shams University Faculty of Medicine and trained in the United Kingdom, Egypt. and at Mass General Hospital.

Peter Gelhaar, JD
Public Member

Peter Gelhaar joined the Board in 1998. He is a partner at the law firm of Donnelly,Conroy & Gelhaar., LLP. He received his Juris Doctor from Boston College Law School in 1982. Prior to founding his law firm in 1991, he served as an Assistant United States Attorney ,specializing in the prosecution of health care fraud and government fraud.

Nishan Kechejian, MD *Physician Member*

Dr. Kechejian joined the Board in 1993. He is a graduate of Georgetown University School of Medicine. Dr. Kechejian is a vascular surgeon in Brockton. Dr. Kechejian is a former Board Chair and currently chairs the Licensing Committee.

Arnold Relman, MD
Physician Member

Dr. Relman joined the Board in 1995. He is a graduate of Columbia University College of Physicians and Surgeons. He chairs the Patient Care Assessment Committee and is one of the nation's leading experts on health care quality issues. Dr. Relman is the former Editor of the New England Journal of Medicine.

Specifically, the Board set these short-term goals:

Goals and Commitments of May 1999 Report

1. Review all physicians with three or more complaints, reviewing physicians with the most complaints first;
2. Review all cases that have been open more than 1 year;
3. Review all cases involving law enforcement agencies;
4. Immediately review all complaints that include allegations of sexual misconduct.
5. Add language to all Physician Profiles about the availability of additional information, including dismissed complaints, by calling the Board.
6. Undertake a more thorough review of its complaint intake process, investigatory, disciplinary and public information systems.

Objective	Status
Review all physicians with 3 or more closed complaints, reviewing physicians with the most complaints first. Actual analysis as follows: • 3 or more closed/ all before 01/93 • 3 or more; at least 1 after 01/93 • 5 or more complaints, at least 1 after 01/93	This process showed that 5 complaints represent a physician complaint history that is statistically significant. Status By Category • 120/120 reviewed • 17/17 reviewed. • 46/46 reviewed. Letters sent in October 1999 to all Physicians with multiple complaints with similar allegations.
Review all cases that have been open more than one year.	**38/38 reviewed.** ▪ 32 finalized with Complaint Committee ▪ 6 pending for possible disciplinary action.
Review all cases involving law enforcement agencies	**19/19 reviewed.** ▪ 3 dismissed. ▪ 1 dismissed with "Letter of Warning." ▪ 7 resolved through Statement of Allegations & Consent Order. ▪ 2 Summary Suspensions. ▪ 6 cases being examined for possible action.
Immediately review all complaints that include allegations of sexual misconduct	**12/12 reviewed.**
Add language to all Physician Profiles about the availability of additional information, including dismissed complaints, by calling the Board	**Accomplished.** Profiles now read: "Additional information about a physician, including dismissed complaints, may be available by calling the Massachusetts Board of Registration in Medicine Phone 617-727-0773"

This progress demonstrates the Board's clear commitment to keeping all promises made in the May Report; especially in the area of patient protection.

In addition to the case review project, the Board directed the staff to address other areas of concern in our Enforcement efforts. Again, the Agency has been highly successful in meeting the goals established in the May Special Report. A brief recap of our progress follows:

Progress on Enforcement Division Initiatives

INITIATIVE	STATUS
Develop a "Guide to Understanding Dismissed Complaints"	Available May 2000.
Implement Screening Committee to accelerate case review process.	Model being tested in 2000.
Implement a strong case tracking system	To be fully implemented in Fall 2000.
Submit legislation to expand the number of members of the Board.	Full recommendations due to Board for action in Sept. 2000.
Finalize and offer legal and regulatory amendments	Full recommendations due to Board for action in Sept. 2000.
Seek supplemental staff	Increase in support form legislature has allowed Agency to fill key positions. Two new investigators hired.

The Board members remain confident that each initiative will be finalized appropriately in the time frame identified. The Board members are grateful for the support from the Legislature and the Cellucci-Swift administration in attaining the resources to make this progress possible. The Board members continue to work to maintain the highest levels of responsiveness, accountability, and excellence in all areas of Agency operations.

Nancy Achin Sullivan
Executive Director

Nancy Achin Sullivan, appointed Executive Director of the Board of Registration in Medicine in October 1999, has been a tireless advocate for patients' rights in Massachusetts and throughout the country. As a teenager, she overcame a battle with Hodgkin's Disease, a lymphatic cancer, to graduate from Harvard University.

After a successful business career, Nancy Achin Sullivan turned to public service. She worked with inner-city children as the Executive Director of the Lowell Girls Club and was active in many civic and cultural activities in her hometown of Lowell. This sense of public service led her to run for the State Senate in 1990. As a Senator, she responded to many health care issues by sponsoring legislation to improve mammography quality, to fund the state Breast Cancer Initiative, and to require insurance coverage for certain cancer treatments. Senator Sullivan's legislative career was cut short when she was diagnosed with breast cancer and was too ill to seek re-election.

As a private citizen, Nancy Achin Sullivan used her knowledge of the legislative initiatives and passion for public service to mobilize community groups and individuals to become involved in changes in health care policy and funding. Despite a recurrence of breast cancer, she accepted the challenge of developing breast cancer education programs for the Mass. Dept. of Public Health while undergoing rigorous cancer treatment. She has spoken to hundreds of community groups throughout the country on the importance of patients' rights and has contributed to many publications on health care issues.

She was honored by Turner Broadcasting Systems as one of five outstanding women in America for her contributions to women's health. She was also the first recipient of the Sullivan Award, named in her honor by the Society of Clinical Oncologists. The Sullivan award recognizes the contributions of non-physicians in the fight against cancer. In 1996, she led the successful effort to implement the Board of Registration in Medicine's Physicians Profiles program, a first-in-the-nation effort to give patients more information about their health care providers.

Nancy Achin Sullivan dedicates her work on behalf of patients to two courageous women; her beloved aunt, Elaine Pyne, and her younger sister, Elizabeth Achin. They died within three days of each other in 1996 after long battles with cancer.

Report of the Executive Director
The Challenge Ahead

They are two powerful forces -- increased demand for access to high-quality health care services and the need to contain costs. As the new millennium dawned, these forces collided and the repercussions will influence our lives for a long time. State receivership of one of the state's largest HMOs has ushered in a new era of uncertainty for both patients and physicians. These opposing forces will continue to exert pressure on health care systems. It is imperative that the Board of Registration in Medicine provides leadership for the people of Massachusetts as we struggle to integrate these opposing forces into a unified impetus for positive change.

Quality Assurance

The Board of Registration in Medicine strengthens health care quality in various ways:

- *Strict licensing guidelines to ensure that only competent physicians are licensed to practice medicine in Massachusetts;*
- *Innovative approaches to error identification and prevention through analysis of outcomes throughout the Commonwealth;*
- *Diligent investigation and appropriate response to patient complaints about physicians;*
- *Meaningful public information programs to assist patients and physicians in making good healthcare decisions.*

Cost Effectiveness

The Board of Registration in Medicine also recognizes and supports the need for cost containment. The agency is able to support efficiency in health care through its work with health care institutions, individual physicians, and other interested parties. Among the areas in which the Board can have impact:

- *Reduced bureaucracy and waste in the Licensing process for individual physicians;*
- *Technological innovations to assist the efforts of teaching hospitals to continue to attract the best and brightest medical students and new physicians;*
- *Data management and analysis to allow health care providers and institutions to benefit from information gathered by BORIM on a broad spectrum of issues*

The Executive Director's report outlines Agency priorities and recaps significant results for 1999. The balance of the report offers detailed overviews of the accomplishments of specific departments during 1999.

Licensing Overview

One of the most important departments within the Massachusetts Board of Registration in Medicine is its Licensing Unit. This Unit researches and reviews all aspects of education, training, and practice for individuals requesting medical licensure in Massachusetts. Along with the vital role of auditing the credentials and qualifications of physicians, the Licensing Unit creates data files that provide a tool for useful analysis of the physician population. The following chart shows the type of information provided by the Licensing Unit on one such characteristic -- gender.

Type of License	Total #	# Men	% Men	# Women	% Women
Full - Active	26,182	18,845	71.9%	7,337	28.0%
Full - Inactive*	1,679	1,255	74.7%	424	25.3%
Total Full	27,861	20,100	72.1%	7,761	27.9%
Limited**	4,401	2,577	58.6%	1,824	41.4%
TOTAL	32,262	22,677	70.3%	9,585	29.71%

* Full-Inactive refers to licensees whose licenses are still current, but who are not seeing patients. Many physicians who retire from active practice choose to keep a Full License in order to participate in various professional organizations.

** Limited licensees are doctors in training (residents, fellows, etc.)

If the current rate of change in demographics continues, the Board projects that a majority of initial licensees (new physicians) will be women in 2 to 3 years. Since the average female physician is 7 years younger than her male counterpart, similar retirement ages will increase the percentage of female doctors drastically in the next few years because the older physician population is overwhelmingly male.

Information concerning other characteristics of the physician population, such as distribution by geographic location, medical specialty, and other characteristics helps to guide policy development at the Board of Medicine and other entities. Complete information about the work and accomplishments of the Licensing Unit can be found in the subsequent chapter "Report of the Director of Licensing."

Enforcement Overview

One of the most vital and visible Board functions involves the Agency's investigation and discipline of physicians. The Agency has been criticized for a perceived lack of aggressiveness in managing consumer complaints and statutory reports of physician misconduct and substandard care. Although there are many reasons for the Agency's performance in 1999, there are no excuses. At the end of 1999, the Board of Registration in Medicine had a 698 open case backlog. The "Open Case Backlog" consists of consumer complaints and statutory reports referred to the Enforcement Unit after review by the Data Repository Committee that have been neither dismissed nor concluded through disciplinary action.

This overview of enforcement activities looks at two key elements: a report on the backlog of open cases and a recap of disciplinary actions taken.

Open Case Backlog

One reason for the unacceptably high number of open cases was the diversion of Board resources and Staff time into the case review process. The Board believed at the time, and still believes, that assuring the public that appropriate decisions had been made in previous case dismissals was of critical importance. There are plans underway to accelerate the Agency's review of the open cases.

The following chart demonstrates that the Agency began 1999 with an unacceptably high backlog of open cases (479) and was unable to lower the existing backlog and meet the needs of new cases. The ending backlog of 698 cases as of 12/31/1999 is extremely troubling to the Board and Staff, but the Agency's leadership team remains confident that recent increases in funding by the Legislature will result in immediate improvement in this area. The Agency has recently doubled its Investigatory Staff, progress made possible by the increased funding.

1999 Open Case Report By Month

Month	Beginning of Month Open Case Backlog	New Cases Opened During Month	Cases Resolved During Month	End of Month Open Case Backlog
Jan	479	31	38	472
Feb	472	67	55	484
Mar	484	60	26	518
Apr	518	73	17	574
May	574	62	36	600
Jun	600	39	36	603
Jul	603	45	17	631
Aug	631	59	21	669
Sep	669	0	37	632
Oct	632	52	30	654
Nov	654	68	35	687
Dec	687	28	17	698
Total	479	584	365	698

In addition to the large number of open cases, the Board is concerned about the age of many of the open cases. Nearly one-third of all open cases has been in process for a year or longer. This delay is not fair to patients or to doctors. The often-repeated *caveat,* "Justice delayed is justice denied," must serve as a constant reminder to the Agency that a timely response to a complaint against a physician is important. There is a constant struggle between the need to prioritize cases of great risk to the public, regardless of age, and the need to resolve even the most minor consumer concern brought to the Agency's attention.

Ongoing improvements to the Board's data tracking and analysis capabilities will allow the staff to identify an appropriate balance between the need to address all complaints in a timely manner and the need to prioritize the cases with the most serious allegations.

The next chart shows the aging of the 698 cases open as of 12/31/99:

Age of Cases	# Cases	% of All Open Cases
0-30 days	**28**	4.0 %
31-60 days	**56**	8.0 %
61-90 days	**49**	7.0 %
90-120 days	**24**	3.3 %
120-150 days	**45**	6.5 %
150-180 days	**51**	7.3 %
181-364 days	**228**	32.7 %
1-2 years	**124**	17.8 %
2-5 years	**66**	9.5 %
5 or more years	**27**	3.9 %
TOTAL	**698**	**100%**

Further analysis of the cases open at the end of 1999 showed that a large number of these open cases involved allegations of substandard care. A disproportionate amount of the work involved in the Case Review Project fell to the Clinical Care Unit. Ordinarily this Unit quickly reviews cases involving allegations of substandard care from both consumers and mandated reporters. The need to call on the expertise of this team for the review of previously dismissed cases made it impossible to meet the review requirements of many new cases.

The Board and staff recognize the importance of resolving these open substandard care cases immediately. An aggressive response through the allocation of new resources is underway to meet this challenge. The following charts show daunting the backlog of substandard care cases was as of 12/31/1999:

Cases in process in the Clinical Care Unit, as of 12/31/99

NUMBER OF CASES	SOURCE OF CASE REFERRED TO CLINICAL CARE UNIT
245	Consumer complaints of substandard care**
250	Statutory reports involving substandard care*
5	Litigation cases
55	Licensing cases

* *(DPH reports, facility discipline reports physicians with medical malpractice reports)*

** *(6 cases docketed in 1997, 51 cases in 1998 and 188 cases in 1999)*

The Clinical Care Unit has a substantial backlog that cannot be resolved without additional resources. The following chart shows how many cases this Unit was able to resolve. The chart divides the cases by referring source.

In 1999, the Clinical Care Unit processed:

NUMBER OF CASES	SOURCE OF CASE REFERRED TO CLINICAL CARE UNIT
113	Consumer complaints of substandard care
29	Statutory reports involving substandard care*
5	Litigation cases
55	Licensing cases

* *(DPH reports, facility discipline reports physicians with medical malpractice reports)*

Clearly the Clinical Care Unit need additional resources to meet the goal of resolving all of these cases by the end of 2000. Board Members and staff leadership are committed to finding the resources for this vital function.

Disciplinary Actions in 1999

An analysis of the open caseload is only one measure of the work that lies ahead for the Board of Registration in Medicine. Another crucial element in enforcement activities is the disposition of cases when they are finalized. Many cases are dismissed. Others are concluded with the imposition of disciplinary action against the physician. It is this measure of performance that has caused the greatest amount of criticism of the Agency. The disciplinary actions for 1999 are as follows:

CATEGORY	# ACTIONS
Total # Physicians Disciplined	**38**
Total Disciplinary Actions	**42 ***
Total Summary Suspensions	**5**

- *Three physicians were disciplined twice in 1999, once at the time of Summary Suspension, again at the time of a final disciplinary order.*

These figures represent the number of disciplinary actions taken. In addition, fifty other actions that are not considered reportable disciplinary actions (such as modifications to probation agreements) were issued by the Board.

The Agency's level of disciplinary action in 1999 was less than has been accomplished in previous years. There are many factors to be considered in evaluating the Agency's performance in this area. A simple comparison to prior years, as seen in the next chart, provides a disappointing review of the Board's enforcement activities in 1999:

YEAR	# PHYSICIANS DISCIPLINED
1999	38
1998	51
1997	48
1996	62
1995	56

There are other possible measures of the Agency's performance. The national patients' rights advocacy group, *Public Citizen*, publishes an annual ranking of state medical boards in terms of physician discipline. The ranking looks at serious disciplinary actions as a percentage of the total number of physicians licensed in each state. Although the Massachusetts Board has some concerns about the methodology of the study, it is appropriate to look at all available measures of performance.

Over the past decade, the Agency's performance on the ranking by *Public Citizen* has been disappointing. It is possible that the methodology will always result in a somewhat lower ranking for states with many physicians, such as Massachusetts. However, it is irrefutable that the Board's ranking relative to other states has plummeted during the past five years.

The following chart compares Massachusetts to other states with physician populations of similar size in terms of the states' performance on the Public Citizen rankings:

Rank 1999	Rank 1998	Rank 1997	Rank 1996	Rank 1995	Rank 1994	Rank 1993	Rank 1992	Rank 1991	STATE (1998 # physicians)
39	**47**	**45**	**43**	**40**	**37**	**45**	**46**	**48**	MASSACHUSETTS (27,622 physicians)
7	10	7/8	8	9	24	22/23	19	23	Ohio (32,220 physicians)
19	13	15	28	21	34/35	35	40	40	Michigan (24,001 physicians)
28	35	42	20	25	19	18	28	20	New Jersey (28,432 physicians)

It is important to note that states with large physician populations can improve. Michigan, which ranked among the worst states for many years consistently ranks among the best states in recent years. In 1994, Michigan and Massachusetts had nearly identical rankings. By 1998, Michigan had improved by over twenty spots. In the same period, Massachusetts fell another 10 spots. Improvement is possible and must be achieved.

In 1999, Massachusetts' 39th place ranking by *Public Citizen* was based on 67 serious disciplinary actions (as defined by *Public Citizen*) imposed upon a physician population of 27,622 licensees. This results in a discipline rate of 2.43 actions per 1,000 licensees. The average rate reported by *Public Citizen* for all states in 1998 was 3.50. The range of disciplinary rates among the states, as reported by *Public Citizen* was 10.34 for Alaska and 0.96 for Deleware.

Table: 1998 Rankings by *Public Citizen* Top 5states, Bottom 5 states, National Totals.

1998 Rank	State	1998 # of Serious Actions	Total # Of Doctors	Serious Actions Per 1,000 Doctors
1	Alaska	16	1,039	15.40
2	Oklahoma	56	6,064	9.23
3	Mississippi	42	4,707	8.92
4	Arkansas	43	5,169	8.32
5	West Virginia	32	4,168	7.68
47	**Massachusetts**	**55**	**26,546**	**2.07**
48	Missouri	27	13,104	2.06
49	Florida	54	40,898	1.32
50	Delaware	2	1,875	1.07
51	Tennessee	12	14,057	0.85
	Total	**2,731**	**726,648**	**3.76**

Table: 1999 Rankings by *Public Citizen* Top 5states, Bottom 5 states, Massachusetts, National Totals.

1999 Rank	State	1999 # of Serious Actions	Total # Of Doctors	Serious Actions Per 1,000 Doctors
1	Alaska	12	1160	10.34
2	North Dakota	14	1596	8.77
3	Wyoming	8	981	8.15
4	Idaho	16	2278	7.02
5	Oklahoma	37	6216	5.95
39	**Massachusetts**	**67**	**27,622**	**2.43**
47	Hawaii	6	3555	1.69
48	Minnesota	21	13275	1.58
49	Tennessee	18	14412	1.25
50	Nebraska	5	4070	1.23
51	Delaware	2	2092	0.96
	Total	**2696**	**770,320**	**3.50**

Public Information Overview

Massachusetts continues to lead the nation in the quality and accessibility of information for patients and the general public. Since the launch of the Physician Profiles Project in 1996, thousands of Massachusetts residents have found the information they needed to make informed health care decisions for their families using this innovative program.

In addition to on-line access to profiles, the Board of Registration in Medicine assists consumers who do not have internet access through a fully-staffed call center. Call Center employees answer questions about Board policies, assist callers with obtaining complaint forms or other documents, and provide copies of requested Profiles documents to callers.

Physician Profiles Output Summary

Year	Calls Received By Call Center	Profiles Mailed/Faxed By Call Center	Physician Profiles Web Site Hits	Total # Profiles *(Web Hits - Call Center Requests Processed)*
1996	17,127	25,771	0	25,771
1997	43,698	57,619	529,250	586,869
1998	30,085	32,316	1,642,500	1,674,816
1999	**22,642**	**22,779**	**2,555,000**	**2,577,779**
TOTAL	**113,552**	**138,485**	**4,726,750**	**4,865,235**

A Message from Jennifer Davis Carey

Director of the Office of Consumer Affairs & Business

I salute the Board of Registration in Medicine for its pro-consumer approach. The Physician Profiles Program is a valuable tool for consumers. I encourage Massachusetts residents to use the Profiles Program to obtain valuable health care information. Consumers can learn about a physician's education & training, area of medical specialty, and insurance plan affiliation. The Profiles Program also supplies information about a physician's history of criminal convictions, malpractice payments, and Board discipline.

Consumers can access the Physician Profiles Program by calling the board's toll-free number

1-800-377-0550

or through Internet Access:

WWW.MASSMEDBOARD.ORG

Pamela Wood
General Counsel

Pamela J. Wood is the Deputy Director and General Counsel of the Board of Registration in Medicine. She joined the Board in October 1999, after serving for many years as a senior attorney specializing in consumer protection issues at the Boston Regional Office of the Federal Trade Commission. She has a demonstrated commitment to consumer advocacy and health care issues, as evidenced by her public service at the FTC and her years of work as a volunteer for the AIDS Action Committee and a workplace consultant in AIDS education.

At the Board, she plans to examine the current regulatory and statutory framework to determine if revisions would enable the Board to increase public responsiveness and carry out its mandates more efficiently.

GOALS FOR 2000

- ***Expand the scope of the Patient Care Assessment (PCA) Unit to maximize Board impact on patient care quality.***
- ***Redraft regulations to clarify the Board's subpoena powers, clarify the Board's public records policies.***
- ***Redraft regulations to expand the Board's grounds for discipline in cases of substandard care.***

The Division of Law and Policy

The Division of Law and Policy of the Board of Registration in Medicine is responsible for advising the Board, the Executive Director, and the agency on legal and policy issues that arise in the course of agency operations. The Division is comprised of four segments: the Legal Unit, Data Repository Unit, Physician Health and Compliance Unit, and the Patient Care Assessment Unit.

The mission of the Legal Unit is to safeguard the fair, legally sound, and efficient processes of the Agency as the Board pursues its mandate to ensure that Massachusetts physicians are competent and practicing in compliance with the law. In carrying out this mission, the Legal Unit must interact with, and be responsive to, the Board, Agency staff, the public, physicians, health care providers and institutions, and other public officials and agencies. The members of the Unit conduct legal analysis on a wide range of topics, including interpretations of the full range of state and federal statutes, regulations and case law governing the practice of medicine; drafting of regulations, policies and procedures; questions of ethics; responses to subpoenas; and issues of confidentiality; among others.

The **Data Repository** counsel receives and processes statutory reports concerning physicians licensed in the Commonwealth. Data Repository Staff work with the Board to review mandated reports to determine which should be referred to the Board's Enforcement Division, and to develop policies relating to statutory reporting. The Data Repository Unit also disseminates information regarding Board disciplinary actions to national data collection systems, and ensures that the information is accurately posted on the Board's Website and in the Physician Profiles.

The **Physician Health and Compliance Unit** was established in 1993 to address the substantial need for expertise about, and special attention to, physicians with chemical dependency problems. An estimated one third of the Board's disciplinary cases involve physicians suffering from chemical dependency, mental illness or physical illness. The Unit evaluates physician self-reports; negotiates and oversees non-disciplinary monitoring agreements (both with and without impairment issues); advises the Board on policy issues; and works with Agency staff on questions involving impairment and probationary matters.

The **Patient Care Assessment (PCA) Unit** executes the Board's responsibilities under regulations requiring most health care facilities to establish and maintain Qualified Patient Care Assessment Programs, which are systems of quality assurance, risk management, peer review, utilization review, and credentialling. In order to carry out its mission effectively and promote cooperation among facilities and physicians, all information reported to and maintained by the PCA Unit is statutorily protected from public disclosure, and is not shared with the Board's Enforcement Division. The staff reviews major incident reports, semi-annual and annual reports, and revised PCA plans, and provides technical assistance as needed to health care facilities. Staff also carries out the direction of the PCA Committee of the Board on special projects, such as issuing PCA Updates and Guidelines, and revising PCA regulations.

Over the past few years, hospital reporting of major incidents, an important component of the PCA program has become more consistent and reliable:

YEAR	# MAJOR INCIDENTS REPORTED
1995	463
1996	509
1997	522
1998	572
1999*	327

** 1999 figures represent only the first three quarters of the year due to guidelines regarding reporting date. In addition, there have been some changes to the reporting requirements for certain categories.*

Ongoing Work of the Division of Law and Policy

Among the issues being addressed by the Division of Law & Policy are a review of the applicability of the Open Meeting Law to the various committees and activities of the Board; the development of recommendations regarding the burgeoning field of telemedicine; and an analysis of the issue of volunteer physicians.

Director of Enforcement

Barbara A.Piselli

Barbara A. Piselli is the Director of the Enforcement Division of the Board of Registration in Medicine. Prior to coming to the Board in October 1999, she served as Chief of the Fair Labor and Business Practices Division of the Massachusetts Attorney General's Office. She also served for many years as an Assistant District Attorney in Middlesex County. She continues her exemplary career of service to the people of the Commonwealth with her appointment to the Board of Registration in Medicine. Under her leadership, the Board plans to pursue an aggressive agenda to investigate and discipline physicians who represent a threat to the safety and welfare of the public.

Enforcement Division Goals - 2000

Reduction in backlog of open cases.

Decrease amount of time required to resolve cases.

Improve communication with people who file complaints during investigation and adjudication of their cases.

Increased number of final disciplinary actions.

Report of the Director of Enforcement
REGAINING PUBLIC TRUST
Accountability & Results

In 1999, the Enforcement Division lost the trust and confidence of many people. The public learned that the Board of Registration in Medicine had failed to discipline a physician with numerous patient complaints alleging serious misconduct. The Agency's failure to manage the Ramos case appropriately resulted in severe criticism for the Board of Registration in Medicine. The criticism was justified and the Board's response was swift and decisive.

Rather than deny responsibility, the Board took action to correct procedural flaws and other mistakes. 1999 was a painful year for the Enforcement Division, but it was also a year of tremendous growth. Each member of the staff accepted responsibility for the Agency's failure in the Ramos case and vowed to regain the confidence of the public. Many hours of auditing prior decisions and investigations assured the Agency leadership that the Ramos case was an anomaly.

The Board and Staff then put plans into place to improve the efficiency and effectiveness of the Enforcement Division. We are confident that we begin the new millennium with the skills and commitment to achieve excellence in meeting our responsibilities to the people of Massachusetts.

The Enforcement Division of the Board is mandated by statute to investigate all potential disciplinary matters involving physicians licensed to practice medicine within the Commonwealth of Massachusetts. The Division is supervised by the Director of Enforcement.

The Enforcement Division is comprised of three units:

1. *Disciplinary Unit,*
2. *Clinical Care Unit*
3. *Consumer Protection Unit.*

Each Unit plays an important role in the Enforcement Division's mission to protect the public from dangerous physicians.

A review of the responsibilities and accomplishments of all three Units follows.

Disciplinary Unit of the Enforcement Division

The Disciplinary Unit is responsible for the investigation, preparation and litigation of all cases that may result in enforcement action. Complaints are referred to the Unit by the Data Repository Committee, the Consumer Protection Unit, and various other sources. The responsibility of the Unit is to pursue complaints against individual doctors efficiently and effectively in order to ensure that the public is protected and that Board statutes, regulations and policies are enforced.

All complaints referred to the Disciplinary Unit are assigned to a prosecutor and most complaints are also assigned to an investigator. Complaints alleging substandard medical care are also assigned to a member of the Clinical Care Unit.

These staff members all work together to gather and organize evidence, negotiate with the physicians who are the subjects of the complaints; draft complaint committee memoranda and other documents to be presented to the Complaint Committee, Board and DALA; and present cases before DALA. They also interface with other state and federal law enforcement officials on coordinated investigations and referrals.

Significant Activities of the Disciplinary Unit in 1999

Commencing in mid-February 1999, following the adverse publicity about the Board as a result of the indictment of Dr. Marcos Ramos by the Suffolk Count District Attorney, the Board made changes in its review of consumer complaints and instituted a case review project overseen by the Unit. More important, the Division prepared to meet its mandate of public protection through the hiring of new Staff, implementation of new management policies, and other changes. The implementation of these changes had a major impact in the functioning of the Enforcement Division during the balance of 1999.

Case Review Project

In response to criticism regarding the Board's failure to take action in a timely manner in the case of Marcos Ramos, M.D., and in the cases of two other physicians who were subsequently summarily suspended, the Board, in a press release dated March 24, 1999, stated that its Complaint Committee would review all physicians with three or more complaints; all complaints open more than one year; all complaints involving law enforcement agencies; and
all complaints with allegations of sexual misconduct. The staff reviewed all open cases in the Disciplinary Unit and identified an additional category of cases for Board review: those cases needing immediate attention. As detailed in the report of the Board Chair, this process has been brought to a successful conclusion.

Screening Committee

The case review project motivated by the issues in the Ramos case highlighted inefficiencies in how initial complaints against a physician were managed. Too many layers of bureaucracy resulted in unacceptable delays in presenting cases to Board members for recommendations on discipline. A more streamlined procedure is being tested as a pilot project in 2000. The goal of the Screening Committee is to bring complaint information before Board members in less time and with more complete information at the initial review.

Case Tracking Improvements

Case lists that include the current status of each case are presented to the Director of Enforcement on a regular basis. Case lists include information about the source of the case, any activity that took place on the case within the past month and a plan for case activity for the upcoming month. These case lists are reviewed with each of the members of the Unit in order to assist in the prioritization of the workload.

Disciplinary Unit Meetings

Unit meetings to discuss case strategy and problems are held regularly. The purpose of these meetings is to assure consistency, enhance the quality of our work product, increase our efficiency and effectiveness, set goals, etc.

Training

Prosecutors and investigators are encouraged to take practice- related courses to enhance their skills and keep abreast of recent legal, medical and investigative techniques and developments.

1999 Disciplinary Unit Accomplishments*

Actions Taken Against Doctors	#
Doctors with Disciplinary Actions	38
Statements of Allegations Issued	29
Summary Suspensions	5
Voluntary Agreements Not to Practice	5

**Outcomes of the 126 cases presented to Complaint Committee that included some type of disciplinary action. Actions taken refer to the number of physician disciplined. Please note that references in this report to disciplinary numbers as reported by a national publication, Public Citizen, use the publication's methodology of reporting all actions. For example, if a physician were reprimanded and fined by the Board, this sanction would count as one discipline by the Board. Public Citizen would report this sanction as two actions, counting the reprimand and fine separately.*

Clinical Care Unit of the Enforcement Division

The Clinical Care Unit was formed in April 1996 to investigate allegations of substandard care and prepares cases for the Board's informal remediation program. The original mission of the Clinical Care Unit was to develop a remediation program authorized under M.G.L. 112 § 5. Over the past three years, the mission of the Clinical Care Unit has become clearer and is perhaps best described in three parts,

1. The identification of substandard care;
2. The analysis of its cause; and
3. Intervention by way of remediation, discipline or both.

Activities of the Clinical Care Unit

The Clinical Care Unit interfaces with the Clinical Care Committee, a committee made up of the Clinical Care Unit staff, two physician Board members, one public Board member, the Legal Counsel for the Board and the Director of Enforcement or her designee. The Committee meets monthly and reviews cases presented by its staff of experienced nurse-investigators. The activity of the Clinical Care Committee largely mirrors the Data Repository Committee insofar as both committees determine whether a case should be closed or referred for further investigation. A Clinical Care memo is prepared for every case that is presented to the Clinical Care Committee, setting forth a summary, analysis and recommendation concerning consumer complaints. The memo also sets forth a detailed description of the physician's Board history. These histories are compiled after a review of closed consumer complaint files and Data Repository files.

The nurse investigator assigned to the particular case presents it to the Clinical Care Committee at their monthly meeting, summarizing the facts and responding to any inquiries from Board members. The first portion of the meeting is dedicated to the review of new cases; the second portion is taken up by remedial conferences with physicians. At its lowest level, remediation takes the form of letters of advice; concern or warning that might be sent to a physician whose case is dismissed. At midlevel, remediation occurs during conferences between the Committee members and physicians about the problems underlying the complaint, and, more importantly, whether the physician has engaged in serious thinking on how to avoid similar problems. At the highest level, remediation is a formal request by the Committee that the physician engage in some type of remedial activity, the successful completion of which may result in the dismissal of the case.

When the Clinical Care Committee recommends remediation, the remediation does not have a disciplinary component. Instead, the Committee intervenes when there are patient complaints about issues that do not rise to a level requiring disciplinary action.

Clinical Support to Other Board of Registration in Medicine Units

The Clinical Care staff members assist the Disciplinary Unit with the investigation and preparation of substandard care cases. This also involves locating an expert who is willing to submit a written report and testify at the administrative hearing, if necessary.

In addition, the Clinical Care Unit's Manager is responsible for the preparation of reports for the Data Repository Committee. The Data Repository Unit receives all statutory reports, including information on all medical malpractice payments in Massachusetts. The Clinical Care Unit staff prepares brief memos that set forth an explanation of the facts, an analysis and a recommendation.

Significant Accomplishments of the Clinical Care Unit

In 1999, the Clinical Care Unit processed:

# Cases	Source of Inquiry
113	Consumer complaints of substandard care;
29	Statutory reports involving substandard care*
5	Litigation cases
55	Licensing cases

At the end of 1999, the Clinical Care Unit had a significant backlog of cases. Additional resources have been identified by Board leadership to address this backlog in 2000.

# Cases in Backlog	Source of Backlog Referrals
245	Consumer complaints of substandard care;**
250	Statutory reports involving substandard care*
30	Litigation cases
0	Licensing cases
525	**TOTAL BACKLOG 12/31/1999**

* *(DPH reports, facility discipline reports physicians with medical malpractice reports)*

** *(6 cases docketed in 1997, 51 cases in 1998 and 188 cases in 1999)*

CONSUMER PROTECTION UNIT

The Consumer Protection Unit was created as a result of recommendations contained in the January 1992 Final Report of the Blue Ribbon Task Force, to make the Board more accessible and responsive to the public. It is responsible for processing all complaints received by the Board. Complaints are reviewed within two weeks of their receipt. During 1999, the Unit docketed and opened 608 cases. The Unit is responsible for the work of the Triage Committee, the Mediation Program, and other Patient Advocacy initiatives.

Triage Committee

The Consumer Protection Unit is responsible for the organization, facilitation, and execution of the triage of all consumer complaints that the Board receives. In 1999, the Consumer Protection Unit was integrally involved in the creation and design of the Screening Committee, which the Board directed staff to set up. The Screening Committee will eventually replace triage as it currently operates and include Board members in the review of every piece of consumer correspondence. During the interim, complaints continue to be reviewed at a weekly triage meeting comprising representatives of the Consumer Protection, Litigation, Legal, and Clinical Care Units.

Voluntary Mediation Program

The Voluntary Mediation Program was developed to improve the quality of doctor-patient relationships in cases in which communication problems have negatively affected medical care. In 1999, seven cases were mediated, six of which were referred to the Voluntary Mediation Program in 1999, and the seventh was referred in 1998. All but one of the seven – 85% -- resulted in an agreement.

Public Access/Outreach

Another major responsibility of the Consumer Protection Unit is providing information to the public and to governmental and other agencies for the protection of the public. This part of our mission includes responding to consumer inquiries, assisting other government agencies, speaking to consumer groups and at hospitals and other healthcare organizations about the Board's complaint process, and drafting and revising Board publications and forms.

Licensing Director Rose Foss and her staff accepting the Pride in Performance Award from Board Chair Mary Anna Sullivan, MD

Rose M. Foss,CMSC has been the Director of Physician Licensing for the Commonwealth of Massachusetts since April, 1996. Prior to her present position, Rose was the Director of Medical Staff Services for Northeast Health Systems and has 23 years experience in medical staff services and health care. She has a B.S. from Lesley College School of Management and has been certified by the National Association of Medical Staff Services (NAMSS) since 1983. She is co-founder of the Massachusetts Association of Medical Staff Services (MAMSS) and served as president from 1885 to 1986. She was Chairman of the NAMSS Education Council from 1990 to 1991 and a member of the NAMSS Board. She has lectured at NAMSS Annual Conferences and MAMSS education conferences and most recently was guest speaker on licensing issues at the Administrators in Medicine (AIM) Licensure Workshop in Philadelphia.

LICENSING DIVISION GOALS FOR 1999

Provide on-line access for all applicants requesting applications.

Research options for safe and accessible storage of nearly 50,000 records that are currently stored on site at the Board's offices, such as scanning and electronic storage or storage at a record retention site.

Continue implementation of new Consolidated Licensing and Regulatory Information System (CLARIS) to improve data quality.

Report of the Licensing Director

The Licensing Division is primarily responsible for processing full license applications that enable physicians to practice medicine independently in the Commonwealth. The Licensing Division also processes initial limited license applications for physicians participating in training programs. Full licenses are renewed every two years and limited licenses are renewed at the end of each academic year. Processing a license application requires collection of data from primary sources that includes verification of medical education, licensing examination scores, postgraduate training, evidence of professional experience and physician profiles from the Federation of State Medical Boards, National Practitioner Databank and the American Medical Association. License applications with legal, medical or malpractice issues are referred to the Legal Division or Physician Health Services for further review and may be referred to the Licensing Committee. License applications with education issues or competency issues are reviewed by the Licensing Committee. In addition to processing license applications, the Licensing Division is also responsible for providing verification of the status of a physician's license for state licensing boards, healthcare facilities, credentialing services and consumers. In addition to the status of a license, the Licensing Division also provides information on open and closed complaints against the physician and some statutory issues.

1999 Licensing Statistics

Licenses Approved by the Board	
Initial Full licenses	1, 670
Full renewals	21,141
In process 12/31/99	321
Initial Limited Licenses	1,509
Limited renewals	3,246
Limited applications in process	36
Temporary (initial) Licenses	10
Temporary renewals	7
Licenses Verifications Processed	6,420
Copies of renewal applications	867

An explanation of the different categories of physician licensure follows:

Limited License

A limited license enables a physician to obtain training in an ACGME-approved training program in a Massachusetts hospital or other health care facility in the Commonwealth. The physician with a limited license may only practice medicine in the designated program and its affiliates. The Licensing Division staff and Residency Program Coordinators at the teaching hospitals work together to ensure that all qualified applicants are approved for licensure prior to their training start dates. A limited license certificate, specific to hospital and training program, is generated for each applicant. Annual Limited License Workshops are held in various locations in the Commonwealth to provide an education resource for Residency Program Coordinators on limited application revisions and legal issues, and to ensure that we are meeting the needs of the training programs.

Full License

Full licensure allows a qualified physician to practice medicine in the Commonwealth without restriction. All applicants for a full license must meet the Board's criteria for pre-medical and medical education and fulfill the postgraduate training requirements. Eligibility requirements include two years of pre-medical education, a minimum of four years of medical school education, and a M.D. or D.O. degree. Candidates for full licensure who are graduates of medical schools in Canada and the United States must have one year of training in an ACGME-accredited training program. Graduates of international medical schools are required to have two years of post graduate training in an ACGME-accredited training program the United States or Canada. All physicians requesting full licensure must have passed a qualifying examination, i.e. USMLE Steps 1, 2 and 3, National Boards, FLEX, LMCC, or a State Exam if taken prior to 1970.

Temporary License

Temporary licensure may be granted to a qualified physician who is licensed to practice in another state or territory or in the District of Columbia or in another country seeking a license for the following reasons:

(A) To accept a temporary faculty appointment certified by the Dean of a medical school in Massachusetts for purposes of medical education in an accredited hospital associated with the medical school. This license is granted for a maximum of three years, renewable at eight-month intervals.

(B) To permit a physician to act as a substitute physician for a Massachusetts practicing physician. This license is granted for a maximum of three months.

(C) To permit a physician to enroll in a course of continuing medical education in Massachusetts for a maximum of three months.

(D) To permit a physician to serve as visiting faculty member in an accredited hospital associated with a medical school in Massachusetts for not more than thirty days.

Renewals

Physicians with full licensure in Massachusetts are subject to renewal of their license every two years on their birth date. Renewal requirements include fulfillment of a fixed number of continuing medical education credits to maintain an active license. Inactive status may be granted to physicians with a Massachusetts license who are not practicing medicine in the Commonwealth. A physician on inactive status may return to active status by acquiring the required CME credits.

Committee on Acupuncture

A Committee of the Board of Registration in Medicine

In June 1987 the Board of Registration in Medicine appointed a Committee on Acupuncture, composed of four acupuncturists, one physician with acupuncture experience, one public member and one physician member of the Board. In 1987 the Committee on Acupuncture drafted a set of regulations allowing acupuncturists to become licensed. A public hearing was held in October 1987 on these regulations and they became law on January 22, 1988. The first licenses were issued on July 7, 1988 and as of September 16, 1999 the Committee on Acupuncture has granted 756 licenses.

The officers of the Committee on Acupuncture are John G. Myerson, Ph.D., Lic.Ac. Chairman; Weidong Lu, Lic.Ac. Vice Chairman and Wen Juan Chen, Lic.Ac. Secretary. The remaining members are Mary Anna Sullivan, M.D., Nancy Lipman, Lic.Ac. and Amy Soisson, Esq.

The Committee on Acupuncture works in cooperation with the Board to regulate the practice of acupuncture in Massachusetts. Below are some of functions of the Committee on Acupuncture.

- setting standards for acupuncture licensure
- approving acupuncture schools and training programs
- reviewing applications for licensure
- setting standards for safe practice, and
- disciplining acupuncturists who engage in misconduct
- interpretation of the regulations and/or discussion on any relevant issues

The Committee on Acupuncture meetings, which are open to the public, are held every 4 months (March, June, September and December) at the Board of Registration in Medicine, 10 West Street, Boston, MA.

Before an acupuncturist can practice, either a full or temporary license must be obtained. A full licensee is designed for those who plan on establishing a practice in accordance with the Acupuncture Statute and 243 CMR 4.00 and 243 CMR 5.00.

A temporary license is designed to allow an acupuncturist to practice acupuncture on an individual or patient only in the course of (1) supervising interns in a Committee on Acupuncture approved internship program; (2) demonstrating acupuncture techniques as part of an educational seminar or program; (3) participating in a Committee on Acupuncture approved post graduate clinical training program.

Failure by a licensee to follow the laws and regulations dealing with acupuncture may be grounds for a disciplinary action. The nature of the complaint(s) received

by the Board's Disciplinary unit vary; some of the complaints received to date range from allegations of misleading advertising to sexual misconduct. All complaints are investigated by the Board's Enforcement Unit and then presented to the Committee on Acupuncture with a recommendation for a final disposition; the Committee on Acupuncture, however, makes the final decision. In the past complaints have been settled through one of the following actions:

- an Assurance of Discontinuance
- a Letter of Concern;
- a Letter of Warning
- an Indefinite Suspension or
- a Dismissal